Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRIDE
5701 MAPLE AVENUE SUITE #100
DALLAS TX 75235

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

XL SPECIALTY INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1908

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pride obtained pre-authorization on this case on 02/11/2010 for Pride program and it was approved with authorization #4240080 and good until 04/01/2010. Additional authorization was approved for an additional 10 visits with authorization #4240080 and good until 05/30/2010. The claims were all billed to the carrier and we received a denial of code W-12-based on 'Extent of Injury'. The extent of injury that we are aware of is for Degenerative Disc Disease (DDD), which we received a PLN 11 for, however we are not treating the patient for that, but only for the compensable injury for Lumbar Sprain/Strain."

Amount in Dispute: $22,622.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for medical treatment the requestor provided to the claimant between February 4, 2010 and April 20, 2010. The provider billed almost $29,000 for the services underlying the disputed charges, and submits that it is entitled to reimbursement in excess of $22,000. The carrier submits that no reimbursement is due for the disputed services because the treatment was not offered for compensable conditions. The carrier believes the compensable injury is limited to a lumbar spine sprain/strain. The carrier formally disputed the compensability of lumbar degenerative disc disease. …The parties previously went through the administrative hearings process, and it was determined that the compensable injury does not include disc protrusions at L2 and L5. …While the provider has correctly noted that its bills reference a lumbar spine sprain/strain only, a review of the documents accompanying the disputed bills shows that the provider has diagnosed protrusions and radiculopathy, which are not part of the compensable injury. …the treatment rendered was not dictated by, or made necessary by, the accepted lumbar sprain/strain. Consequently, no reimbursement is appropriate."

Response Submitted by: Flahive, Ogden, & Latson; Post Office Drawer 13367; Austin TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2010	99214	$149.57	$148.42
February 4-5, 2010	99245	$688.70	$0.00
February 4, 2010	97001-GP	$65.05	$65.05
February 5, 2010	99205	$268.69	$268.69
February 5, 2010	97750-FC	$692.80	$692.80
February 26, 2010	64483 and 77003	$276.47	$0.00
February 25, 2010; March 4-5, 2010; March 11-12, 2010; March 17-19, 2010; March 25-26, 2010; March 31, 2010; April 1, 2010; April 7-9, 2010; April 14-16, 2010; April 19-20, 2010	97799-CP-CA	20 days x $1000.00/day	$20,000.00
April 20, 2010	A9300	Not In Dispute	Not In Dispute
April 21, 2010	97750-FC	$519.60	$519.60
April 21, 2010	99455-WP-V5 99080-73	$276.79 $ 13.50	$200.51 $0.00
		TOTAL DUE	$21,895.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305 relates to MDR-General.
3. Texas Labor Code §413.011(d-1) sets out the requirement for carriers to provide copies of contracts.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for obtaining preauthorization.
5. 28 Texas Administrative Code §134.203 sets out medical fee guidelines for workers compensation medical services provided on or after March 1, 2008.
6. 28 Texas Administrative Code §134.204 sets out medical fee guidelines for workers compensation specific services provided on or after March 1, 2008.
7. HCPCS code A9300 was withdrawn by the requestor on March 7, 2012.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1IQ - any network reduction is in accordance with the network referenced above ANSI 45
   - 1MB - reimbursement has been calculated according to the state fee schedule guidelines ANSI W1
   - 1VN - FHN contract status indicator 01 – contracted provider (111-001) ANSI 45
   - W1 – workers compensation state fee schedule adjustment
   - 15 – payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

- 45 –charges exceed your contracted/legislated fee arrangement
- 51 – these are non-covered services because this is a pre-existing condition
- 1HU – review of this code has resulted in an adjusted reimbursement (885) ANSI W1
- 1VP - FHN contract status indicator 03 – no client-provider relationship (111-001) ANSI 45
- 1WB – network import re-pricing – non-contracted provider (113-002) ANSI 45
- 1WH – other import re-pricing was not negotiated (113-012) ANSI 45
- 1IS – any other reduction was determined by the external vendor (113) ANSI 45
- 1WG – other import re-pricing – negotiation (113-011) ANSI 45
- 1IB - the submitted charges are duplicates of previously submitted bills ANSI-18
- 2LG – network in bill header updated to Universal Smart Corp
- 1VX – FHN contract status indicator 11 – negotiated or other pricing (111-011) ANSI 45
- W12 – extent of injury. Not finally adjudicated.
- 2FS – based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed. (6663-022) ANSI B5
- B5 – payment adjusted because coverage/program guidelines were not met or were exceeded
- 3ML and W3 – upon further review-additional payment is warranted ANSI W3

Issues

1. Have the extent of injury issues been resolved?
2. Was the carrier entitled to pay pursuant to an informal/voluntary network contracted rate?
3. Is the requestor entitled to reimbursement for chronic pain management?
4. Is the requestor entitled to reimbursement for Maximum Medical Improvement and/or Impairment Rating?
5. Is the requestor entitled to reimbursement for the FCE?
6. Is the requestor entitled to reimbursement for other professional services?

Findings

1. 28 Texas Administrative Code 133.305(b) states in Dispute Sequence, "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the dispute regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute. The respondent's position summary states, "The carrier believes the compensable injury is limited to a lumbar spine sprain/strain. The carrier formally disputed the compensability of lumbar degenerative disc disease. The parties previously went through the administrative hearing process, and it was determined that the compensable injury does not include disc protrusions at L2 and L5." The Division reviewed the Decision and Order which states "a contested case hearing was held on September 23, 2010, to decide the following disputed issues: 1. Does the compensable injury of May 20, 2009, include L2 and L5 disc protrusions and degenerative disc disease of the lumbar spine…? Upon agreement of the parties Issue No. 1 above was revised as follows: 1. Does the compensable injury of May 20, 2009, include L2 and L5 disc protrusions?" The Contested Case Hearing determined that the compensable injury includes a lumbar sprain/strain; and that the compensable injury does not extend to L2 and L5 disc protrusions. The CCH was affirmed by the Appeals Panel on December 20, 2010. The Operative Report for services rendered on February 26, 2010 (with CPT codes 64483-WP and 77003-WP) indicated a pre and post diagnosis description of "right L5 radiculopathy." The medical billing including the billing diagnosis codes are reviewed. Because the compensable injury does not extend to L4 or L5 disc protrusions, services 64483-WP and 77003-WP are not payable. Furthermore, the Division finds that the requestor sufficiently supported that the remaining services were for the compensable injury. The Division concludes that there are no unresolved issues of extent pertinent to the services in dispute.

2. According to the explanation of benefits, the respondent denied reimbursement based upon "1IQ - any network reduction is in accordance with the network referenced above ANSI 45" and "1VN - FHN contract status indicator 01 – contracted provider (111-001) ANSI 45". Former Texas Labor Code §413.011(d-1) states, in pertinent part, that "…an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the Division if the insurance carrier…has a contract with the health care provider and that contract includes a specific fee schedule…" Furthermore, former §413.011(d-2) requires that "An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by commissioner rule." On June 9, 2011 the Division requested additional information. Specifically, medical fee dispute resolution requested a copy of the contract between the informal/voluntary network and PRIDE; and documentation to support that the requestor was notified in accordance with commissioner rule 28 Texas Administrative Code §133.4 titled Written Notification to Health Care Providers of Contractual Agreements for Informal and

Voluntary Networks. Responsive documents were received on June 24, 2011. Pursuant to 28 Texas Administrative Code §133.4(d)(2))(A) and (B), each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, is required to notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement. The notice must include the name, physical address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider. No documentation was found to support that the notice contained the name, physical address, and telephone number of any workers' compensation insurance carrier given access to the fee arrangement. The Division concludes that the respondent did not meet all the requirements of rule §133.4. Consequently, pursuant to rule §133.4, the insurance carrier is not entitled to pay a health care provider at a contracted fee for the services in dispute. The disputed services will be reviewed in accordance with the applicable Division fee guidelines.

3. The respondent originally denied chronic pain management services rendered on March 17, 18, and 19, 2010 as "payment adjusted because coverage/program guidelines were not met or were exceeded (based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed). Upon reconsideration, these denial reasons were not maintained and will not be addressed in this review. The carrier also denied payment because "…the submitted authorization number is missing, invalid, or does not apply to the billed services or provider." The requestor sought and received preauthorization as follows:
   - Authorization # 4240080 for ten sessions of a chronic pain management program (CPT code 97799), lumbar spine, effective February 11, 2010 to April 1, 2010; and for an additional ten visits effective March 29, 2010 to May 30, 2010

   The carrier's denial reason is not supported. Services are payable in accordance with 28 Texas Administrative Code §134.204 (h) (5) (A) (B) which states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." The Division recommends reimbursement as follows:
   - February 25 to April 20, 2010: 20 days x 8 hrs/day = 160 hrs x $125.00/day = $20,000.00

4. Requestor billed both CPT code 99455-WP-V5 for a Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examination and CPT code 99080-73 for a Work Status Report on April 21, 2010. The documentation submitted by the requestor in this dispute is reviewed. The Division finds that the requestor sufficiently documented the MMI/IR examination and the DWC-73 Work Status Report. 28 Texas Administrative Code §134.204 (j) (3) (A) (i) states, "An examining doctor who is the treating doctor shall bill using CPT code 99455 with the appropriate modifier and (i) Reimbursement shall be the applicable established patient office visit level associated with the examination." The requestor billed with modifier –V5 which is the equivalent to office visit CPT code 99215. §134.204 (l) states, "When billing for a Work Status Report that is not conducted as part of the examinations outlined in subsection (i) and (j) of this section, refer to §129.5. Since the MMI/IR examination was billed according to subsection (j), separate reimbursement cannot be recommended for CPT code 99080-73.
   - 99455-WP-V5: $54.32÷$36.0791 x $133.18 = $200.51
   - 99080-73: $0.00

5. 28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. Requestor billed CPT code 97750-FC on February 5, 2010 and April 21, 2010. The documentation submitted by the requestor in this dispute is reviewed. The Division finds that the requestor sufficiently documented both FCEs as billed. The Division recommends reimbursement as follows:
   - February 5, 2010: $54.32÷$36.0791 x $29.82 = $ 44.89 x 16 units = $718.34, the requestor seeks $692.80, this amount is recommended.
   - April 21, 2010: $54.32÷$36.0791 x $29.82 = $ 44.89 x 12 units = $538.76, the requestor seeks $519.60, this amount is recommended.

6. 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits…."
   - Requestor billed CPT code 99245 on February 4 and 5, 2010. The current Medicare payment policy states in part that "CPT consultation code ranges 99241-99245 and 99251-99255 are no longer recognized for Medicare Part B payment. Although Medicare's policy on consultation codes changed effective January 1, 2010, Medicare also provides guidance to providers on when E&M codes may be appropriately billed." Consequently, no reimbursement is due for CPT code 99245 billed on February 4 and 5, 2010.
   - Requestor billed CPT code 99214 on February 4, 2010 and CPT code 99205 on February 5, 2010. The documentation submitted by the requestor in this dispute is reviewed. The Division finds that the requestor sufficiently documented the services as billed. The Division recommends reimbursement pursuant to 28 Texas Administrative Code §134.203(b) as follows:
     CPT code 99214: $54.32÷$36.0791 x $98.58 = $148.42
     CPT code 99205: $54.32÷$36.0791 x $192.39 = $289.66; the requestor seeks $268.69, this amount is recommended.
   - Requestor billed CPT code 97001-GP on February 4, 2010. The documentation submitted by the requestor in this dispute is reviewed. The Division finds that the requestor sufficiently documented the services as billed. Pursuant to 28 Texas Administrative Code §134.203 (b), the Division recommends reimbursement as follows:
     $54.32÷$36.0791 x $71.29 = $107.33; requestor seeks $65.05, this amount is recommended

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the services in dispute except CPT codes 99245, 64483, 77003, and 99080-73. As a result, the amount ordered is $21,895.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $21,895.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.